Exploring the Impact of the RAC Program on Hospitals Nationwide

Results of AHA RACTRAC Survey, 4th Quarter 2012

March 26, 2013

Agenda

- Thanks for making RAC*Trac* a Success!!
- RAC legal update
- RAC policy update
- Key findings of the RAC*Trac* Report, March 2013
- RAC*Trac* results, Q4 2012
- Deleted and New Questions for April 2013 RAC*Trac* reporting period
- Q&A session

American Hospital Association

RAC TRAC American Hospital Association

American Hospital Association

THANK YOU

Hospitals for Your Help in Making RAC*Trac* Data Collection a Success!

2,335 Responding Hospitals; 1,233 Participating This Quarter

RAC Legal Update

Lawrence Hughes, Assistant General Counsel

CMS Changes Rebilling Policy

- CMS publishes in Monday, March 18 *Federal Register* (Vol. 78, No. 52):
  - Administrator's Ruling (pps. 16614 – 16617) http://www.gpo.gov/fdsys/pkg/FR-2013-03-18/pdf/2013-06159.pdf
  - Proposed Rule (pps 16632 – 16646) http://www.gpo.gov/fdsys/pkg/FR-2013-03-18/pdf/2013-06163.pdf

- CMS terminates Part A to Part B Rebilling Demonstration

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CMS's Longstanding Policy on Rebilling

- Hospitals permit to bill for *only a limited list* of Part B inpatient services,
  - ***provided*** the services are billed **within 1 year** of the provision of the services (i.e., the timely filing period)

- AHA, five hospital systems sued HHS last year
  - ***Legal claim:*** CMS's policy is not consistent with Medicare law that requires payment for all reasonable and necessary care
  - ***Requested remedy:*** Court should overrule CMS's policy and order full reimbursement to hospitals for the care they provided

- AHA's view of CMS's recent actions:
  - CMS's interim policy change is a victory for hospitals; its long-term proposed solution is not.
  - It's essential to continue the AHA litigation.

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Administrator's Ruling

- Establishes interim policy
  - Effective March 13, 2013
  - Remains in effect until CMS issues final rule

- **What is the interim policy established by the Ruling?**
  - When a Medicare review contractor denies a Part A claim because the inpatient admission was not reasonable and necessary, Hospital may submit a Part B inpatient claim for reasonable and necessary services that would have been payable had the beneficiary originally been treated as an outpatient instead of an inpatient
  - **Except** for those services that specifically require outpatient status (eg., outpatient visits, emergency department visits, and observation services)

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Administrator’s Ruling (cont.)

- Hospitals may bill separately for the outpatient services furnished during the 3-day (or 1-day for non-IPPS hospitals) payment window prior to the inpatient admission, including observation and other services that were furnished in accordance with Medicare's requirements

- Hospital would bill for these services on a Part B outpatient claim, which is not be subject to the usual timely filing restrictions
  - May **NOT** be included on the Part B inpatient claim

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Administrator's Ruling (cont.)

- Rebilling permitted for all denials:
  - Issued while this Ruling is in effect
  - Issued prior to the effective date of this Ruling, but for which an appeal is pending
  - Issued prior to the effective date of this Ruling, but for which the time to appeal has not expired

- Does **NOT** apply where:
  - Time to appeal a denial has already expired
  - Hospital determines (for example, through utilization review or other self-audit) that the inpatient admission was/is not reasonable and necessary

- Rebilled Part B claim is an "adjustment" bill

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Administrator's Ruling (cont.)

- Hospital may **NOT** have simultaneous requests for payment under both Parts A and B for the same services provided to a single beneficiary on the same dates of service.
  - Can no longer appeal the Part A claim once a Part B claim has been submitted
  - However, still able to exercise full appeal rights for the rebilled Part B claim
- If a Part B claim is submitted without withdrawing an appeal request, the Part B claim will be denied as a duplicate
  - Choice either to:
    - No longer pursue an appeal of the Part A claim denial *OR*
    - Withdraw any pending appeal request
- Unless and Until the request for withdrawal is received, all pending Part A appeals will continue to be processed
  - New limited scope of review for appeals

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Proposed Rule

- CMS proposes to pay Hospitals for all reasonable and necessary Part B services that would have been payable had the beneficiary originally been treated as an outpatient instead of an inpatient
  - **Except** for those services specifically requiring an outpatient status

- *WHEN?*
  - An Medicare review contractor denies a Part A claim because the inpatient admission was not reasonable and necessary, OR
  - The hospital determines, after a beneficiary is discharged, that his or her inpatient admission was not reasonable and necessary

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Critical Difference in Proposed Rule

- CMS proposes to **apply the timely filing restriction to the rebilling** of all Part B inpatient services
  - Requires that rebilled claims for Part B services must be filed within 1 year from the date the services were originally provided

- **The Problem for Hospitals:**
  - Recovery audit contractors typically reviews claims that are more than a year old, so CMS's proposal would again leaving hospitals without fair reimbursement for the care they provide to Medicare patients

- Deadline to comment: **May 17, 2013**

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RAC Policy Update

RAC Policy Overview

- Current Trends
  - RAC activity continues growing at rapid pace
- Audit Issues
  - Persistent operational problems
- Appeals Issues
  - Lengthier, more challenging process
- Legislative Update

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AHA RAC and Audit Resources

AHA is Helping Hospitals Improve Payment Accuracy

- RAC Updates on latest RAC news and other RAC resources: www.aha.org/rac
  - RAC home page has been redesigned
- AHA RACTrac: www.aha.org/ractrac; www.aharactrac.com
- 2012 AHA Audit Series: www.aha.org/auditseries
- Email RAC Questions: racinfo@aha.org

AHA Audit Education Series™

Key Findings of Q4 2012 RAC*Trac* Report

Executive Summary

- 2,335 hospitals have participated in RAC*TRAC* since data collection began in January of 2010. 1,233 hospitals participated this quarter.
- Participants continue to report increases in RAC activity:
  - Nearly 60,000 medical record requests have been requested of survey respondents since last quarter.
  - Over 30,000 complex audit denials have been issued to respondents since last quarter.
- Nearly two-thirds of medical records reviewed by RACs **did not** contain an overpayment, according to the RAC.
- 61% of medical necessity denials reported were for 1-day stays where the care was found to have been provided in the wrong setting, not because the care was medically unnecessary.

Executive Summary (cont.)

- Hospitals reported appealing more than 40% of all RAC denials, with a 72% success rate in the appeals process.
- Nearly three-fourths of all appealed claims are still sitting in the appeals process.
- 63% of all hospitals reported spending more than $10,000 managing the RAC process during the fourth quarter of 2012, 43% spent more than $25,000 and 13% spent over $100,000.
- Over one-third of participating hospitals reported having a RAC denial reversed through utilization of the discussion period.

Importance of Consistent Reporting

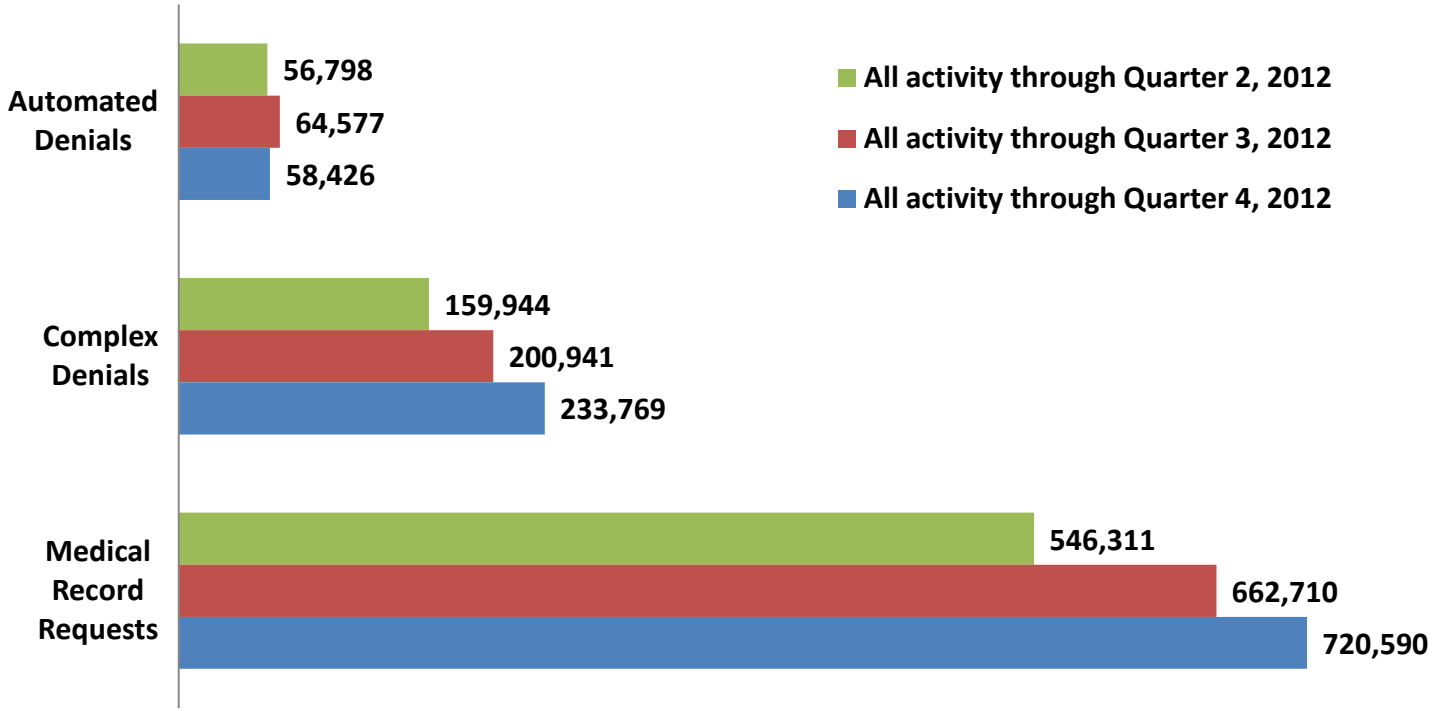
- Participation in RAC*Trac* declined during Q4 2012
  - 66 fewer hospitals reported data during this quarter overall
  - 257 hospitals reported in Q3 that did not in Q4
  - 164 hospitals reported in Q4 that did not in Q3

- The continued, consistent participation of hospitals in RAC*Trac* is essential to the AHA's RAC advocacy efforts
  - The survey is voluntary and we appreciate all of your efforts!!!
  - By reporting your data on a consistent basis, it enables the AHA to create high quality, reliable data points that can be used to show the increasing impact of the program on providers to CMS, Congress and the media.

RACTrac Results, Q4 2012

Participants continue to report dramatic increases in RAC denials and medical record requests.

Reported Automated Denials, Complex Denials and Medical Records Requests by Participating Hospitals, through 4th Quarter 2012*



*Response rates vary by quarter.

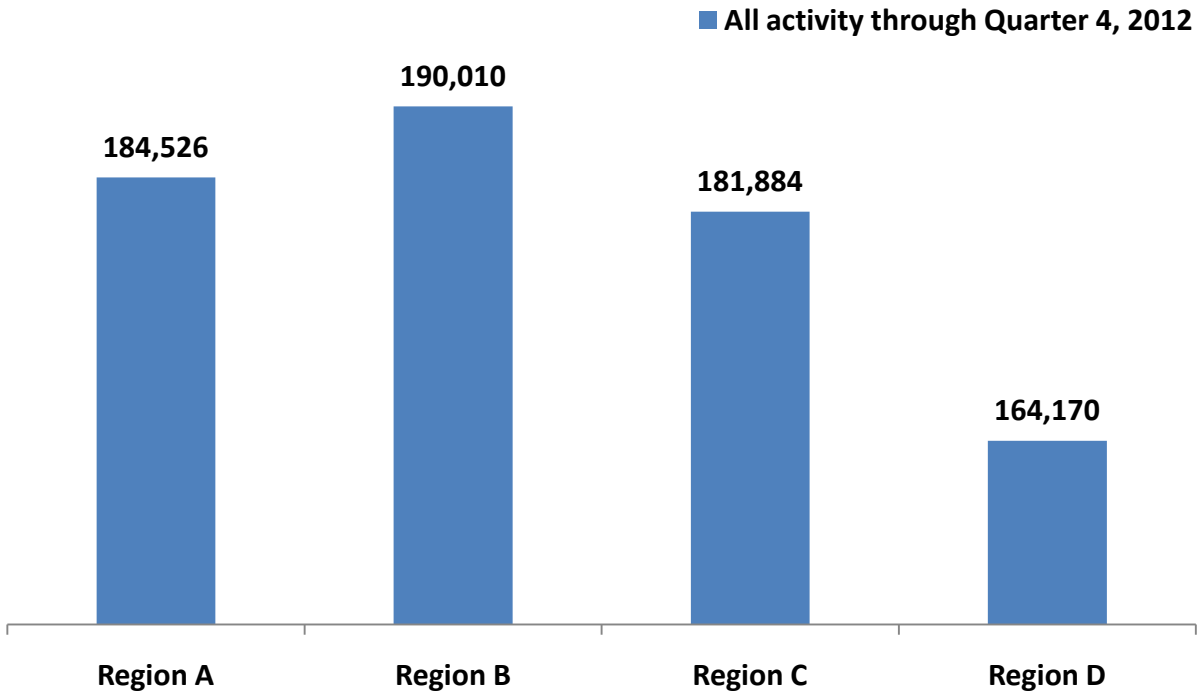
Source: AHA. (January 2013). RAC*TRAC* Survey

AHA analysis of survey data collected from 2,335 hospitals: 1,998 reporting activity, 337 reporting no activity through December 2012. 1,233 participating hospitals this quarter. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

The Per Hospital Number of Medical Record Requests is Highest in Region A and D; while the Highest Total Number of Requested Records was Reported in Region B.

Number of Medical Records Requested from Participating Hospitals With Complex Medical Record RAC Activity, through 4th Quarter 2012*

Average Number of Medical Record Requests per Reporting Hospital, through Q4, 2012	
Region A	1,183
Region B	868
Region C	671
Region D	1,026



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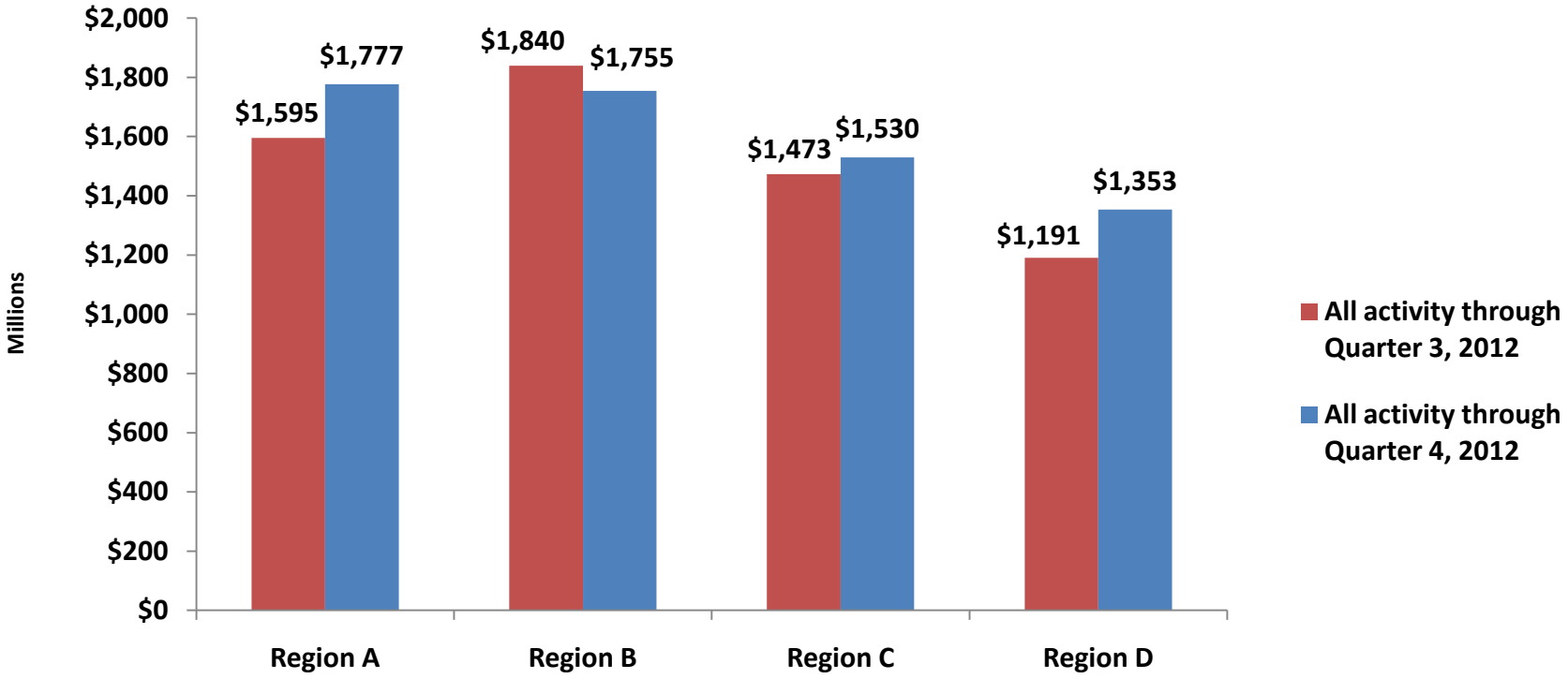
Among participating hospitals, $6.4 billion in Medicare payments were targeted for medical record requests through the 4th quarter of 2012.

Medicare Payments Associated with Medical Records Requested from Participating Hospitals, through 4th Quarter 2012, in Millions*



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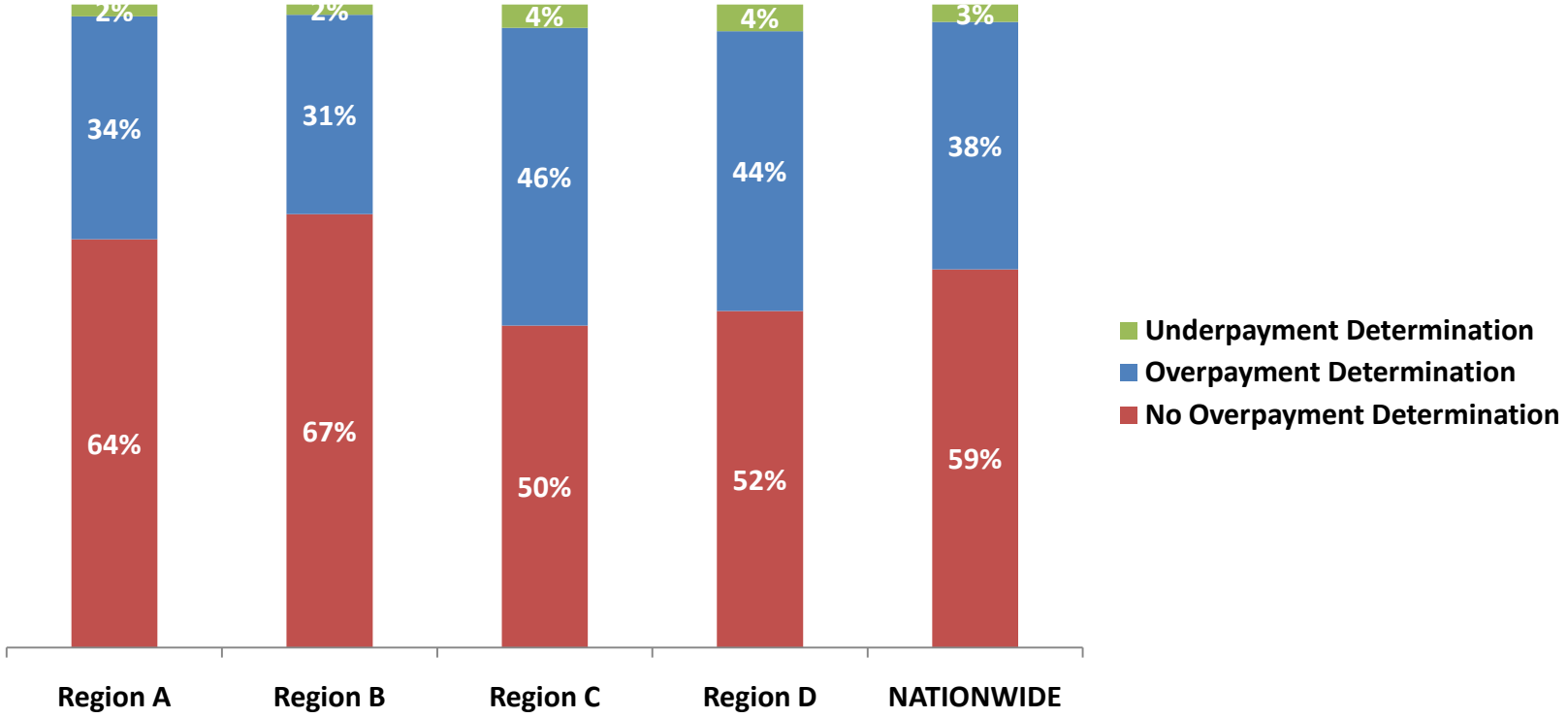
59 percent of medical records reviewed by RACs did not contain an improper payment.

Percent of Completed Complex Reviews with and without Overpayment or Underpayment Determinations for Participating Hospitals, by Region, through 4th Quarter 2012



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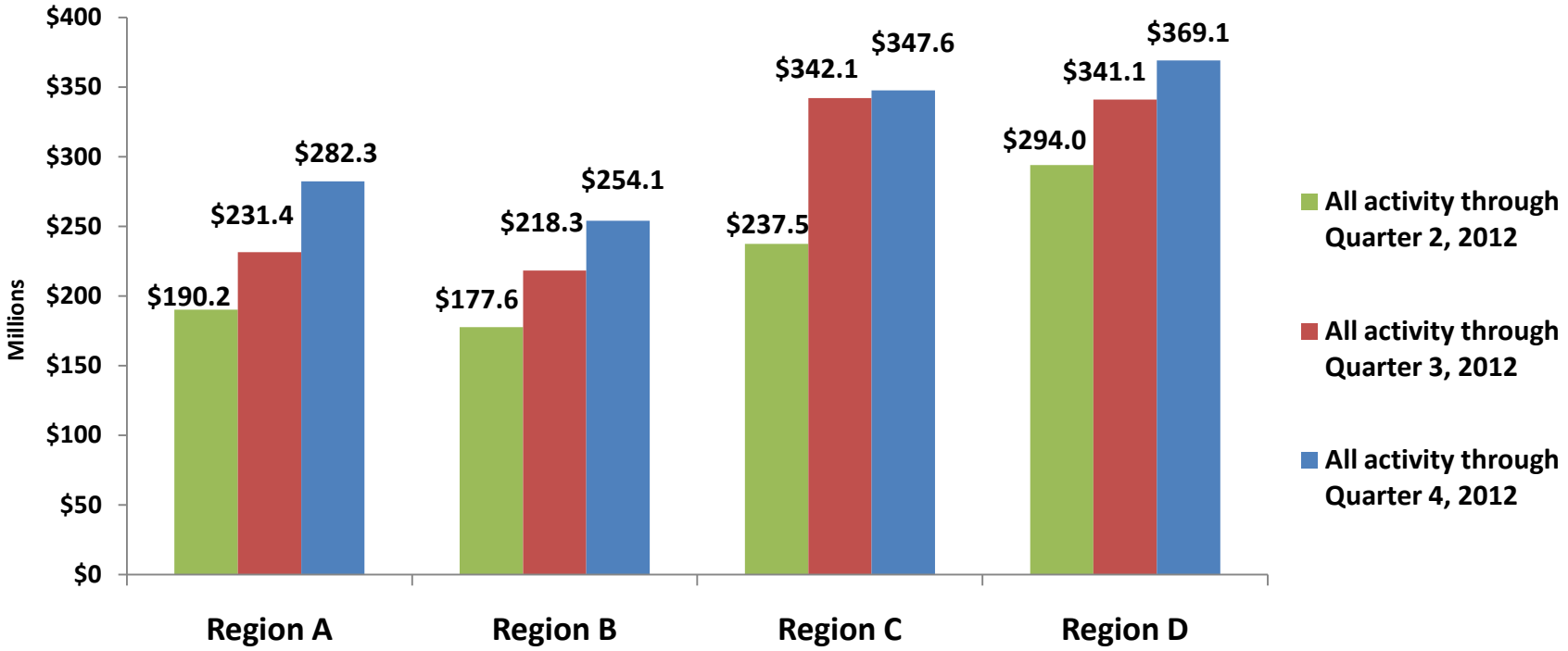
RAC Denials

$1.3 billion in denials were reported through the fourth quarter of 2012.

Dollar Value of Automated and Complex Denials by RAC Region for Participating Hospitals, through 4th Quarter 2012, in Millions*



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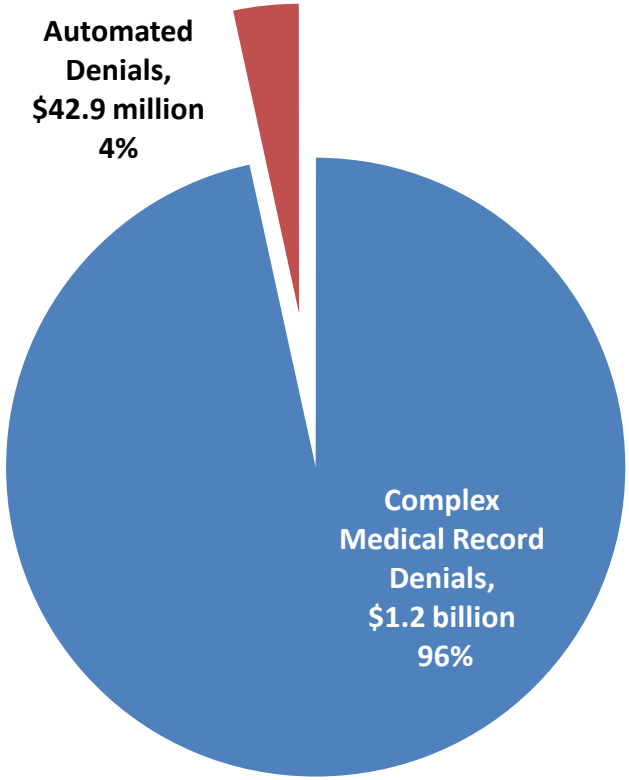
96% of denied dollars were for complex denials.

Percent and Dollar Amounts of Automated Denials Versus Complex Denials for Participating Hospitals, through 4th Quarter 2012



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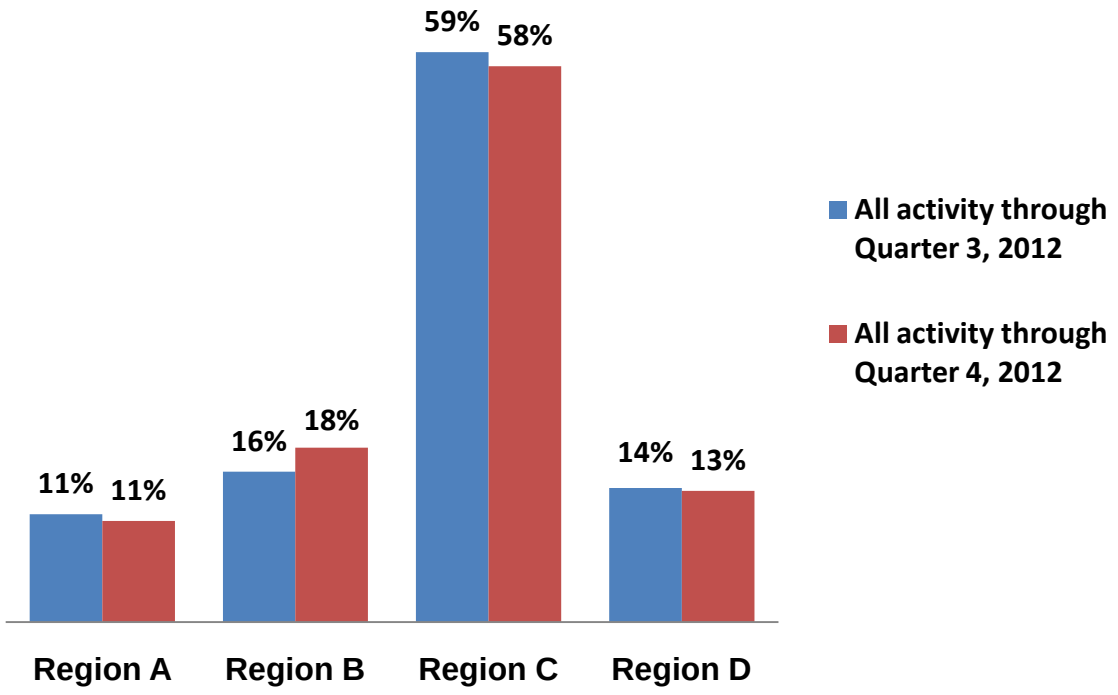
Region C continues to experience the vast majority of all automated denial activity.

Percent and Number of Reported Automated Denials for Participating Hospitals, by Region, through 4th Quarter 2012

	Total Number of Automated Denials by RAC Region through 4th Quarter 2012
Region A	6,139
Region B	10,582
Region C	33,744
Region D	7,961



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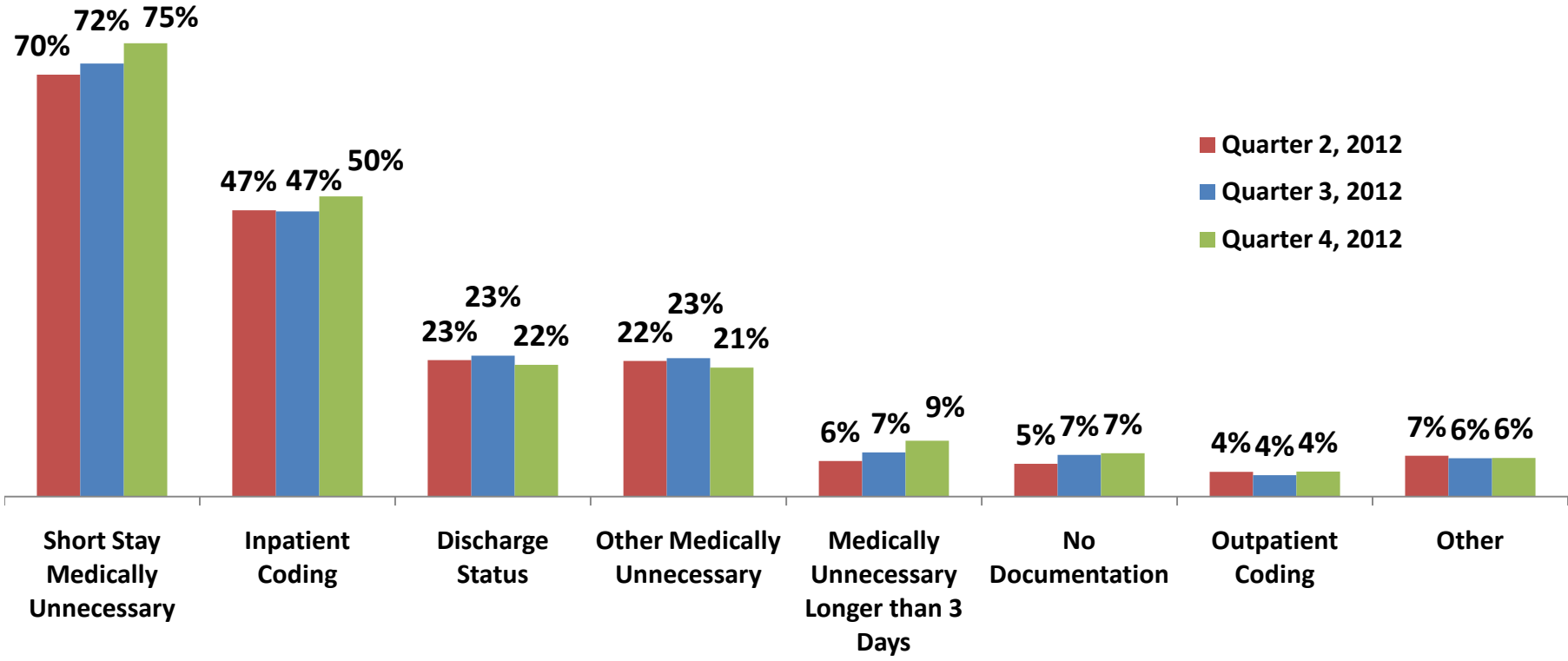
The most commonly cited reason for a complex denial was 'short-stay medically unnecessary.'

Percent of Participating Medical/Surgical Acute Hospitals with RAC Activity Experiencing Complex Denials by Reason, 2nd , 3rd and 4th Quarter, 2012

Survey participants were asked to select all reasons for denial.



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Nearly 70% of short-stay medical necessity denial dollars were denied because the care was provided in the wrong setting, not because the care was not medically necessary.

Reason for Medical Necessity Denials by Length of Stay Among Hospitals Reporting Medical Necessity Denials, through 4th Quarter 2012

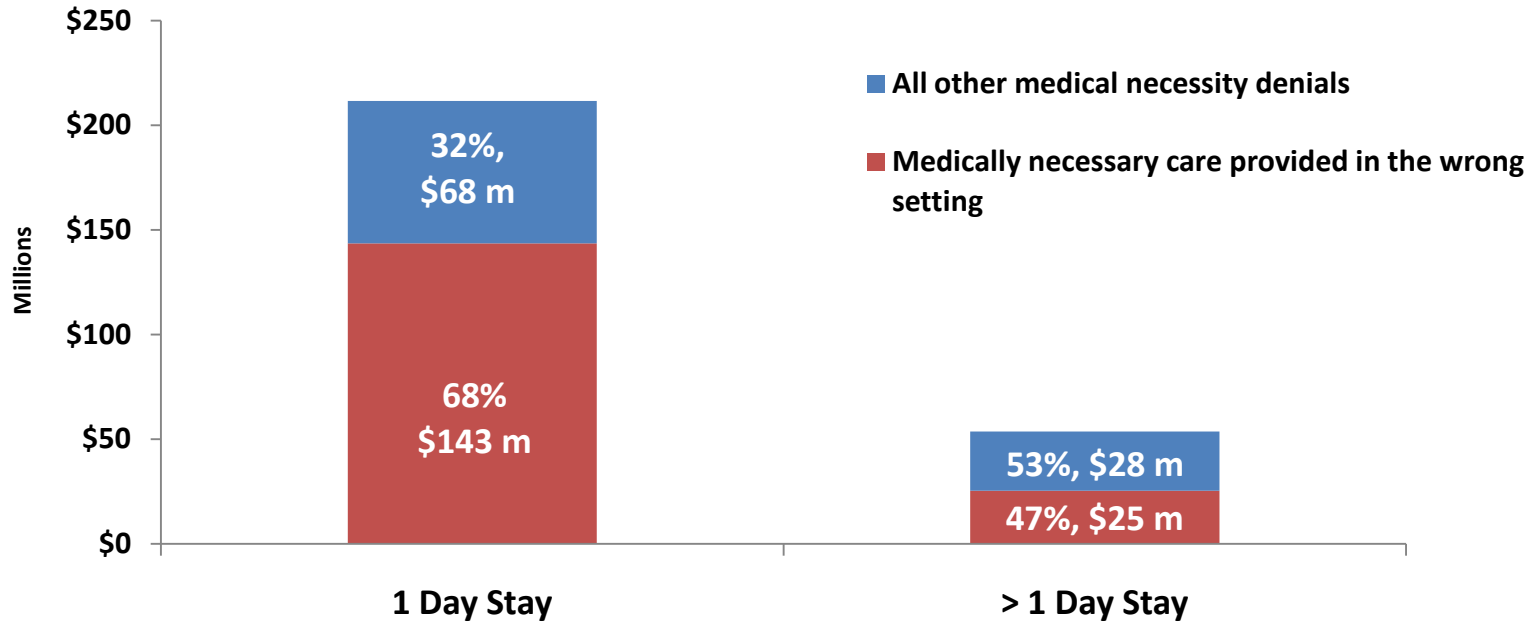

Chart includes hospitals reporting any inappropriate setting denials or the ability to track inappropriate setting denials. Not all hospital decision-support systems and RAC*TRAC* *compatible vendors have made accommodations to allow hospitals to answer this question yet. As a result, the volume of medical necessity denials for inappropriate setting may be under-represented in this chart. Furthermore, older RAC claims may not be classified as "inappropriate setting" by the hospital.*

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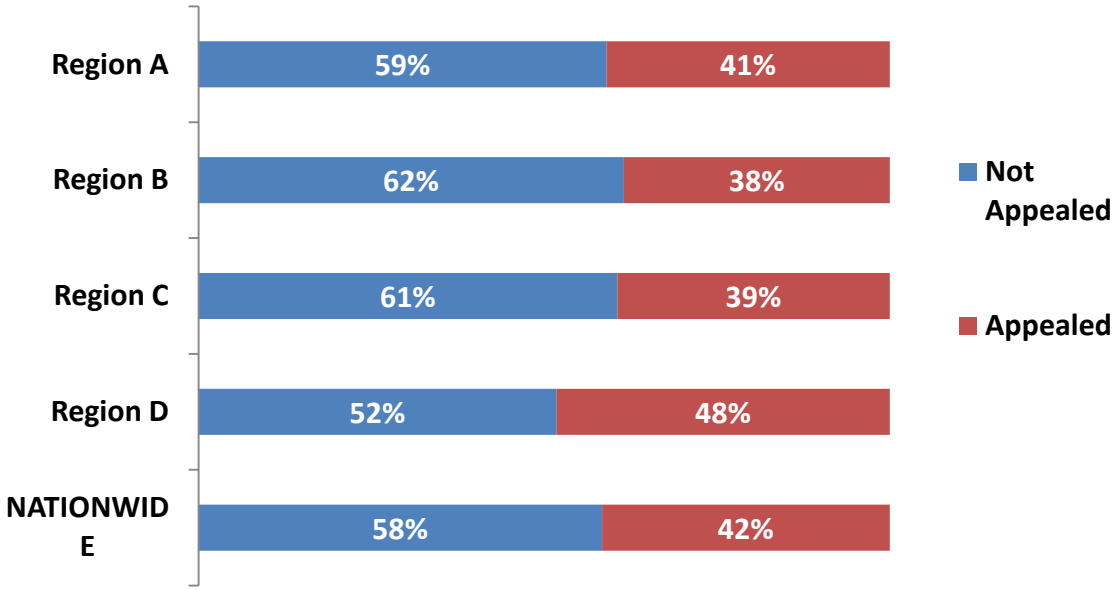
Appeals

Nationwide hospitals report appealing more than 40% of all denials. In Region D, nearly half have been appealed.

Total Number and Percent of Automated and Complex Denials Appealed by Hospitals with Automated or Complex RAC Denials, by Region, through 4th Quarter 2012

	Total Number of Denials Available* for Appeal	Total Number of Denials Appealed
NATIONWIDE	292,195	121,672
Region A	61,332	25,122
Region B	61,265	23,566
Region C	99,726	39,301
Region D	69,872	33,683



** Available for appeal means that the hospital received a demand letter for this claim, as a result of either automated or complex review.*

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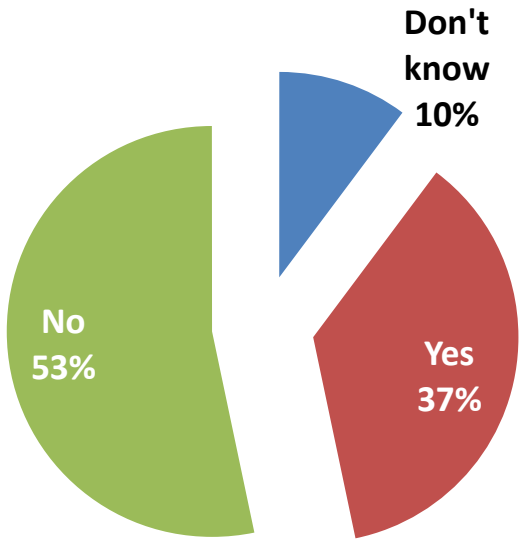
Over one-third of participating hospitals report having a denial reversed during the discussion period.

Percent of Participating Hospitals With Denials Reversed During the Discussion Period, National and By Region, 4th Quarter 2012

Reversed Denials by RAC Region

	Yes	No	Don't Know
Region A	58%	31%	11%
Region B	34%	55%	11%
Region C	28%	62%	10%
Region D	35%	55%	10%



*The discussion period is intended to be a tool that hospitals may use to reverse denials and avoid the formal Medicare appeals process. All RACs are required to allow a **discussion period** in which a hospital may share additional information and discuss the denial with the RAC. During the discussion period a hospital may gain more information from the RAC to better understand the cause for the denial and the RAC may receive additional information from the hospital that could potentially result in the RAC reversing its denial.*

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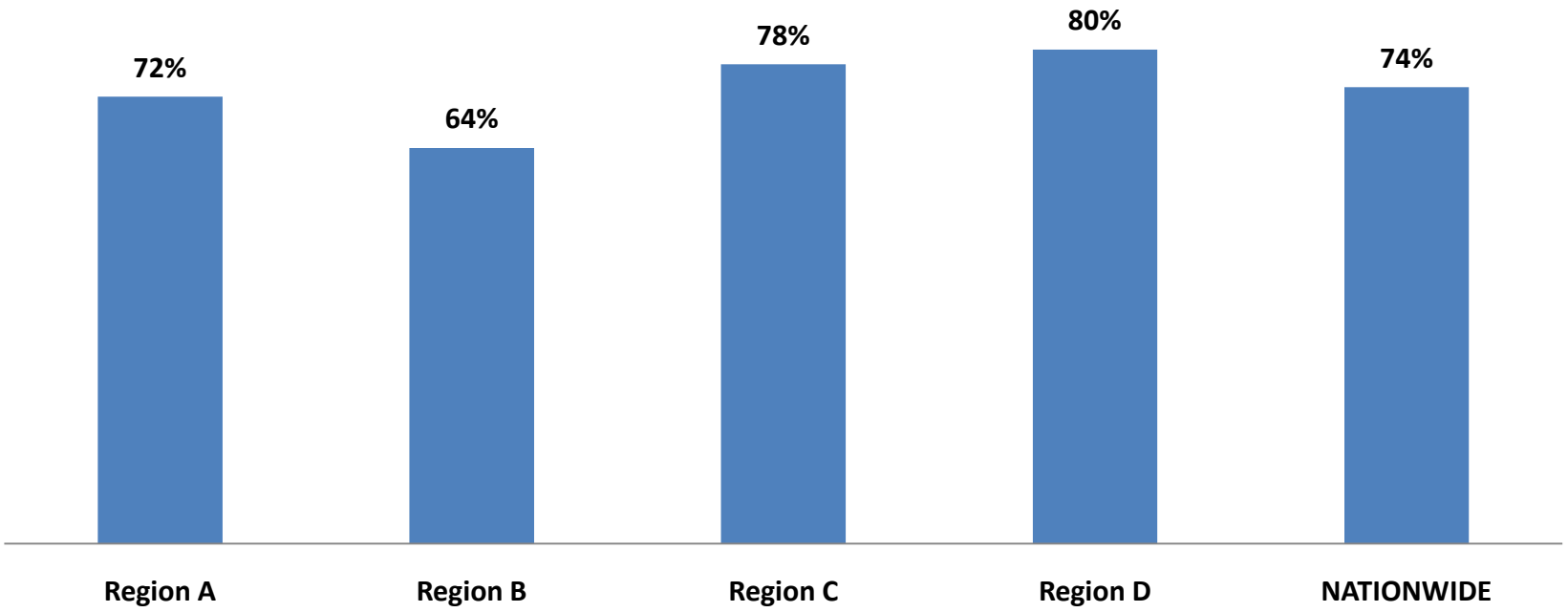
Nearly three-fourths of all appealed claims are still sitting in the appeals process.

Percent of Appealed Claims Pending Determination for Participating Hospitals, by Region, through 4th Quarter 2012*



Manual survey entries only for Region A.

*Response rates vary by quarter.

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Of the claims that have completed the appeals process, 72% were overturned in favor of the provider.

Summary of Appeal Rate and Determinations in Favor of the Provider, for Hospitals with Automated or Complex RAC Denials, through 4th Quarter 2012*

				Completed Appeals		
	Appealed	**Percent of Denials Appealed**	**Number of Denials Awaiting Appeals Determination**	**Number of Denials Not Overturned from Appeals Process** (Withdrawn/Not Continued)	**Number of Denials Overturned in the Appeals Process**	**Percent of Appealed Denials Overturned** *(as a Percent of Total Completed Appeals)*
NATIONWIDE	105,944	42%	79,493	7,367	18,905	72%
Region A*	9,394	50%	6,810	503	2,081	81%
Region B	23,566	38%	15,121	2,174	6,243	74%
Region C	39,301	39%	30,565	2,143	6,490	75%
Region D	33,683	48%	26,997	2,547	4,091	62%

***Manual survey entries only for Region A. Due to survey submission error, total appeals may be greater than the sum of pending/withdrawn/overturned appeals.*

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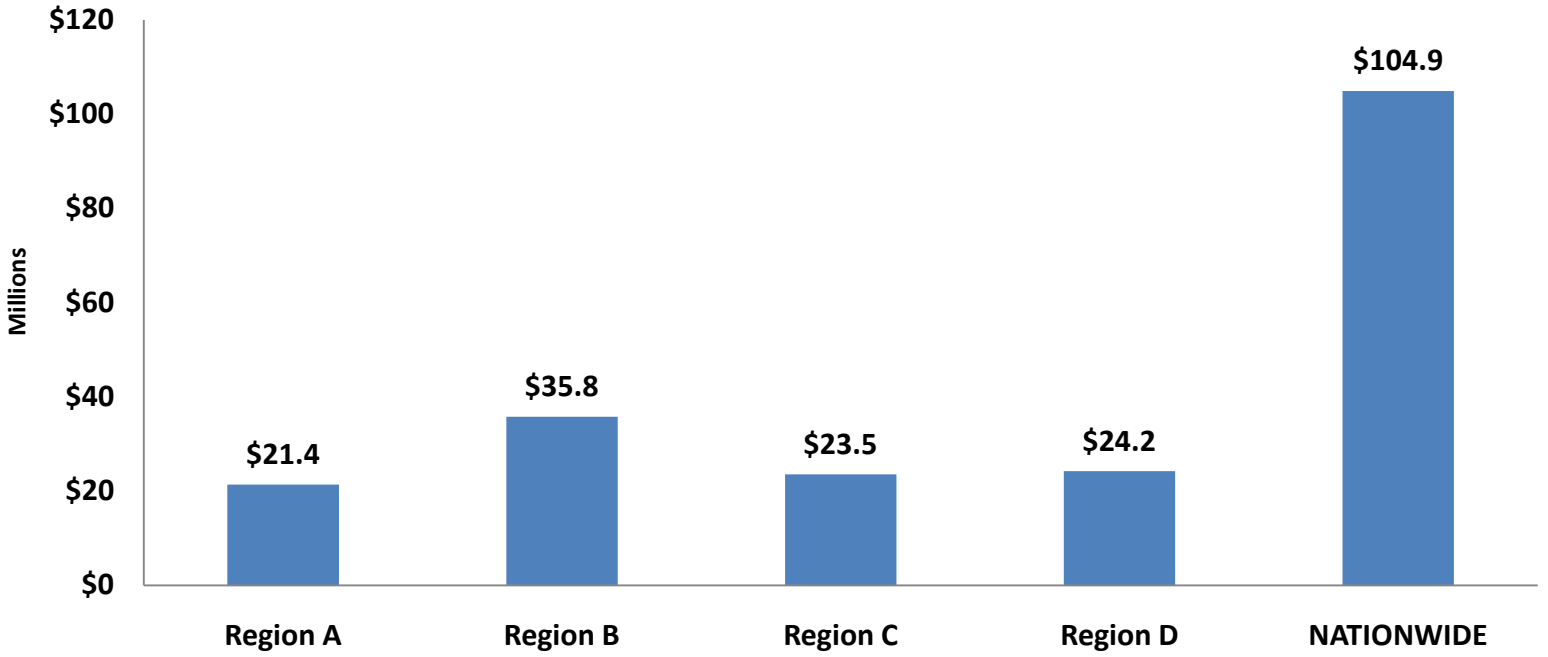
Hospitals reported a total of $104.9 million in overturned denials, with $35.8 million in Region B alone.

Value of Denials Overturned in the Appeals Process, by Region, through 4th Quarter 2012, in Millions



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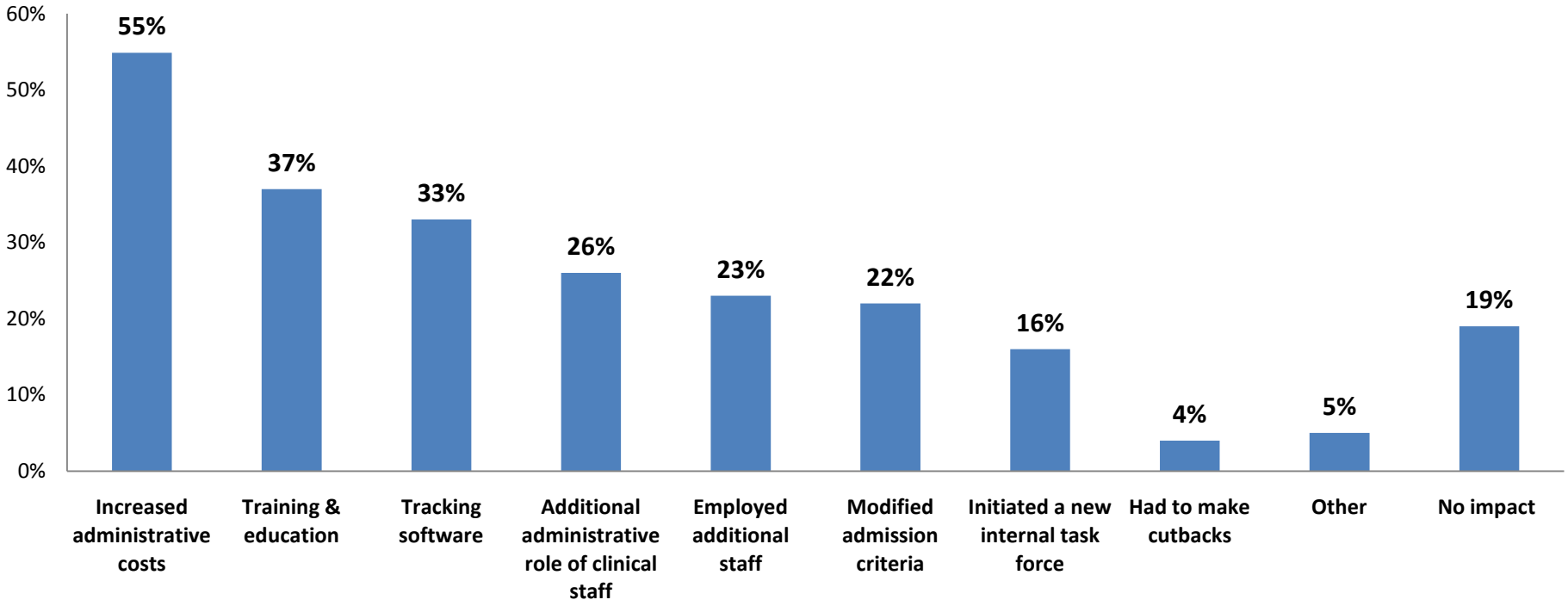
Administrative Burden

81% of all participating hospitals reported that RAC impacted their organization this quarter and 55% reported increased administrative costs.

Impact of RAC on Participating Hospitals* by Type of Impact, 4th Quarter 2012



** Includes participating hospitals with and without RAC activity*

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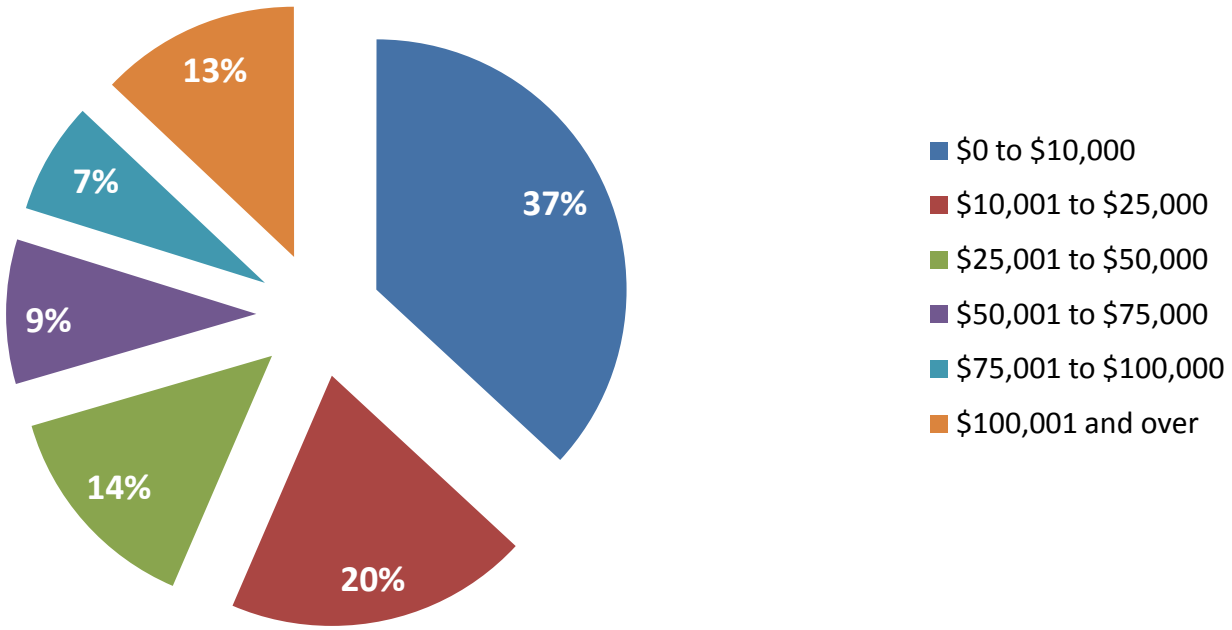
63% of all hospitals reported spending more than $10,000 managing the RAC process during the fourth quarter of 2012, 43% spent more than $25,000 and 13% spent over $100,000.

Percent of Participating Hospitals* Reporting Average Cost dealing with the RAC Program, 4th Quarter 2012



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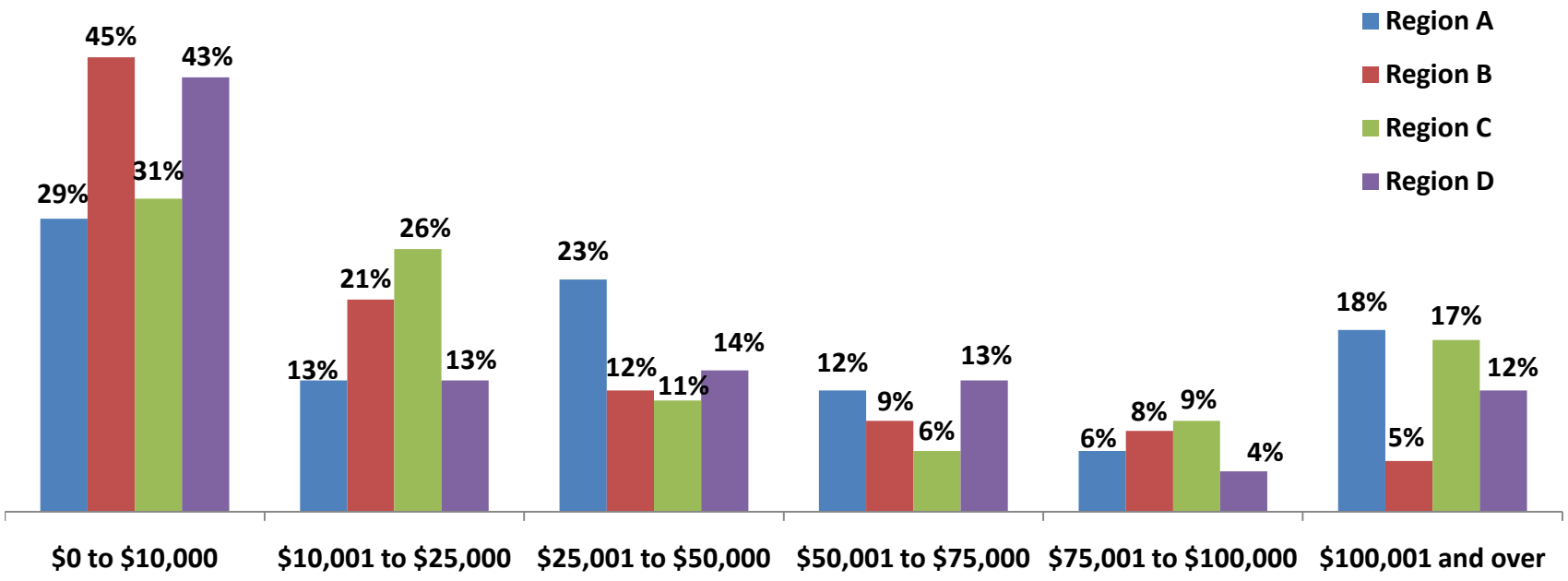
The additional cost of managing the RAC program varies by region.

Percent of Participating Hospitals* Reporting Additional Cost of Managing the RAC Program, by Region, 4th Quarter 2012



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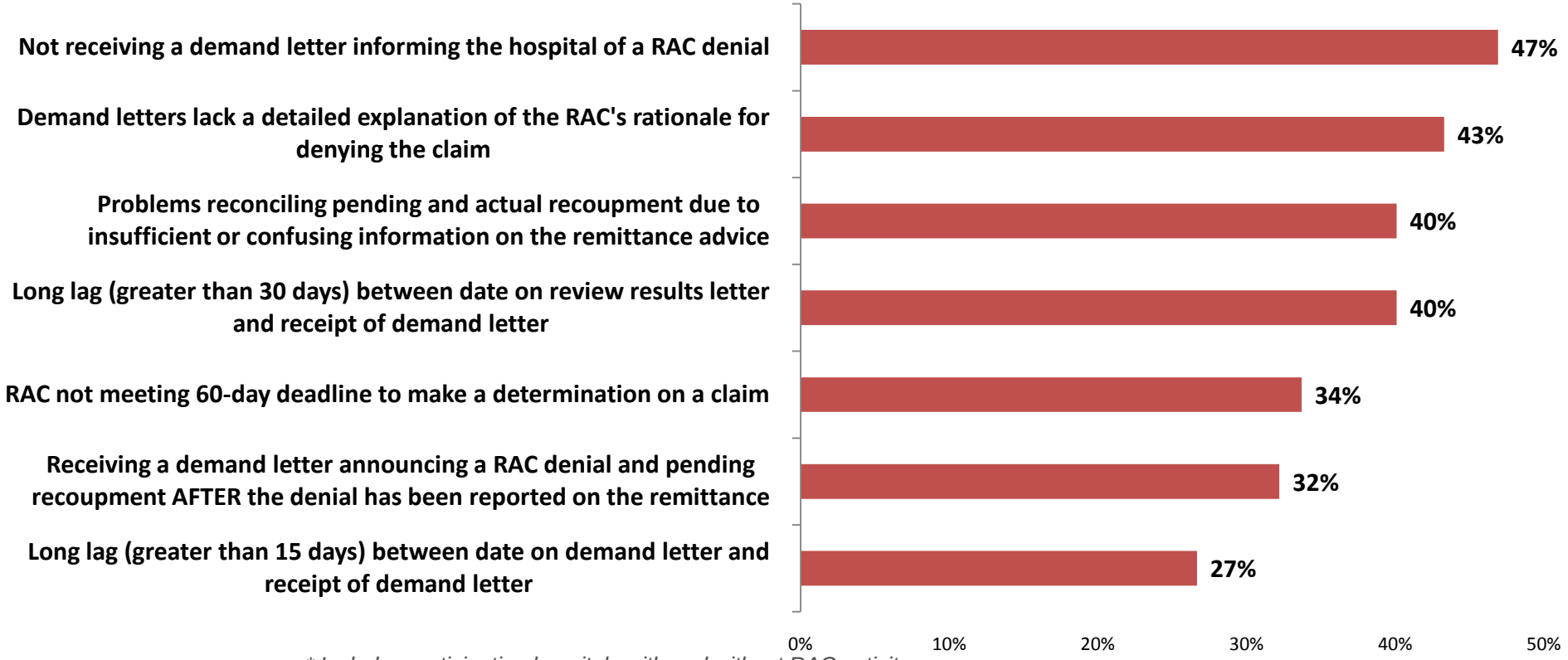
Nearly 50% of hospitals reporting RAC process issues cite 'not receiving a demand letter' as an issue.

Percent of Participating Hospitals Reporting RAC Process Issues, by Issue, 4th Quarter 2012



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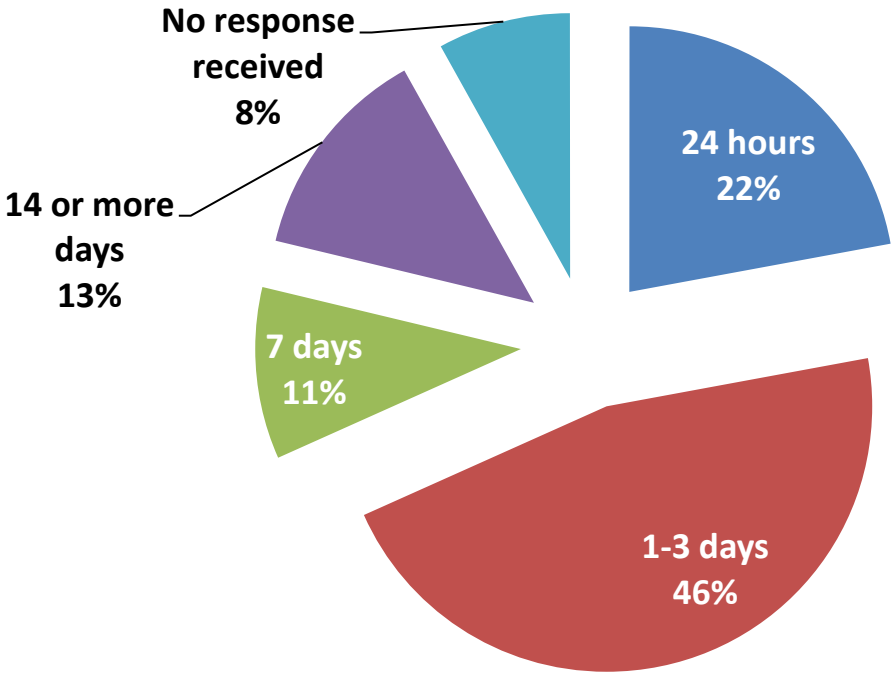
The average wait time for a RAC response varied significantly, with over 20 percent of hospitals reporting they did not receive a response from their RAC within 2 weeks.

Average Number of Days it Took RACs to Respond to Hospital Inquiries for Participating Hospitals, 4th Quarter 2012



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RAC response time varied by region.

Average Number of Days For RACs to Respond to Hospital Inquiries for Participating Hospitals, by Region, 4th Quarter 2012

	24 hours	1-3 days	7 days	14 or more days	No Response Received
Region A	**36%**	**44%**	**6%**	**9%**	**5%**
Region B	**10%**	**50%**	**17%**	**13%**	**10%**
Region C	**27%**	**44%**	**6%**	**14%**	**9%**
Region D	**17%**	**47%**	**14%**	**16%**	**7%**

Source: AHA. (January 2013). RAC*Trac* Survey
AHA analysis of survey data collected from 2,335 hospitals: 1,998 reporting activity, 337 reporting no activity through December 2012. 1,233 participating hospitals this quarter. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

Deleted and New Questions in Manual-Entry Survey Section (Administrative Burden)

What Changes are Being Made and Why?

- The AHA's RAC*Trac* team continues to evaluate the questions asked to determine if the survey can be streamlined to reduce provider burden

- However, AHA will also continue to add questions to the survey, when appropriate, to address essential areas of RAC policy advocacy
  - AHA is adding new questions around the appeals process this quarter to evaluate the effectiveness of the appeals process
  - The results from the new questions will be used to support legal actions and continued advocacy with Congressional and legal audiences, CMS

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Deleted Question

- AHA is eliminating the following question from the survey:
  - "Please estimate the total hours or number of FTEs related to all activities related to managing the RAC process within your organization by type of staff this quarter"
    - Provider feedback indicated that the question was extremely difficult to gather information for
    - Results had largely "topped out" and were not providing new information; it is now widely known that the RAC program places great administrative strain on an organization, due to previous results

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Added Questions

- How many claims has your hospital appealed to the ALJ level, in total?
  - Requests hospitals provide the cumulative number of appeals they have taken to the ALJ level
- How many claims are currently awaiting determination at the ALJ level?
  - Asks hospitals to report the number of appeals that are awaiting a determination from the ALJ
- For how many inpatient cases has the ALJ awarded your hospital A) full inpatient payment; B) full outpatient payment instead of inpatient; C) partial outpatient payment, i.e. payment only for ancillary services?
  - While complicated, this question asks respondents to provide information around the results of their ALJ cases.
- For how many appeals has the ALJ taken longer than the statutory maximum of 90 days from the hospital's request for a hearing to issue a determination?

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Added Questions (continued)

- What is the longest delay your hospital has experienced awaiting a determination at the ALJ level?
  - This question will have a dropdown box (less than 90 days, 90-100 days, etc.) that asks hospitals to state, for a single claim, their longest wait for a determination

- Have you escalated any appeals to the Medicare Appeals Council (Stage 4) as a result of an untimely response of the ALJ? For how many appeals?
  - The first question is Yes/No; the second asks for a specific number if a hospital has escalated a claim for this reason

- How many cases have been remanded to the QIC by the ALJ?

- Of the cases the ALJ remanded to the QIC, how many were awaiting a second QIC review, prior to the release of the Administrator's Rule? How many claims were awaiting a second QIC review for more than 60 days?
  - Remands were a big issue – while it is unlikely that they will be allowed again in the final rule, we want to show that the remand process was not working

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Added Questions (continued)

- What percent of your RAC-audited hospital claims are requested after the timely filing deadline, i.e. one year from the date of service, has passed?
  - This question will have a dropdown box (45-54%, 55-65%, etc.) and will serve as a critical data point in advocacy
- How many appeals has your hospital experienced, since the start of the RAC program, at the QIC appeal level?
- Has your hospital received communication from the QIC reporting that they are unable to complete an appeal review within their 60 day window and offering an option to escalate the appeal to the ALJ? For how many claims?
  - The first question is Yes/No; the second asks for a specific number if a hospital has received this type of communication
- Have any claims initially denied by a RAC for DRG Validation been converted by an appeals body to a full medical necessity denial?
  - This is a Yes/No query

American Hospital Association

For more information visit AHA's RAC*TRAC* website:

http://www.aha.org/RACTrac